PRK/ LASIK Application Form
Warfighter Refractive Eye Surgery Program (WRESP)
(Read Instructions completely before filling out application)

Instructions:

1. *Type or print legibly all information on this form.*
2. ***Enter all dates in the format dd-mmm-yyyy (example: 05-Aug-2006).***
4. ***Applicant must DISCONTINUE CONTACT LENS WEAR for a minimum of 15 days prior to initial screening. Patient's will not be referred to a laser center until corneal stability is demonstrated.***
5. ***If you are on aviation, special duty status or jump status, FIRST Contact your Unit Surgeon to determine if you need to complete any additional waiver's or authorizations before receiving surgery.***
6. *Submit this completed form and your signed Commander's Authorization to "GPRMC Refractive Surgery Coordinator" by fax (210-295-2749) or by mail (2410 Stanley Rd Suite 121, Ft Sam Houston TX 78234-6230).*
7. *Incomplete forms will not be accepted and returned. Please allow three weeks for processing.*
8. *You will be notified of your status by email so please make sure that the email address you provide is one that you regularly use.*

GPRMC Warfighter Laser Centers	*Location*
Wilford Hall Medical Center	Lackland AFB, San Antonio, TX
Carl R. Darnall Army Medical Center	Ft Hood, Killeen, TX
US Air Force Academy	Colorado Springs, CO (Near Ft Carson)

a. Last Name:	First Name:	MI:	b. Rank/ Grade:	c. Date of Application:

d. SSN: (no dashes)	e. Date of Birth:	f. Age:	f. Sex: ☐M ☐F	g. Primary MOS:	h. ETS Date	i. Likely to Deploy or PCS in the next 12 months? ☐Deploy ☐PCS Date (if known):

i. Unit

k. Applicant's Duty Address:

_____
_____
_____
_____

Duty Phone:
(Commercial): ( ) -
(DSN): ( ) -
(FAX): ( ) -

j. Primary email address:

l. Applicant's Home Address:

Street: _____
_____
City: _____ State: _____
Zip: _____

Phone: ( ) -

n. Special Duty Status (Check with you Unit Surgeon before submitting):

☐Aviator ☐Ranger ☐HALO ☐Airborne

☐Special Operations ☐SCUBA ☐Air Assault ☐Other: _____

MANDATORY QUESTIONS:

Your initials indicate you completely understand the statement or question. If you don't understand, ask your local eye care clinic for help.

1. I understand that PRK/ LASIK may not correct all of my myopia, hyperopia, or astigmatism and that I may still need to wear glasses or contact lenses after PRK for best correction of my vision. Init:
2. I understand that if PRK/ LASIK is not successful there is a possibility that I may lose my special duty status and/or may never meet vision standards for application into special duty programs. Init:
3. I understand there is a chance I cannot be fitted with contact lenses after PRK/LASIK. Init:
4. I understand there is a small risk of not meeting relevant vision standards after PRK/LASIK. As a result, I may be disqualifed permanently from certain career fields or even continued military service. Init:
5. I understand that during my evaluation at a GPRMC laser center, I may be disqualified as a PRK/LASIK candidate and will not be treated. The final decision will be made by my surgeon. Init:
6. If I am disqualifed as a PRK/LASIK candidate after arriving at a GPRMC laser center, I mat not be eligible for reimbursement of expenses incurred for travel to/from the DoD laser center, including, but not limited to, travel, meals, and lodging. (This does not apply if I am unit-funded.) Init:
7. Any history of eye injury or other eye history that might impact PRK/LASIK? ☐Yes ☐No Explain if answered "yes": Init:

Signature of Applicant:	Print - (Last name, First name, MI)	Date:

Encl 3

FOR ALL CANDIDATES:

Commander's Authorization
Warfighter Refractive Eye Surgery Program (WRESP)

1. I hereby give my endorsement/permission for the following Soldier to be evaluated and considered for enrollment in the WRESP and for their PRK/LASIK eye surgery if eligible.

Name: _____ **Rank:** _____
Last, First, MI

SSN: _____ **ETS Date:** _____ **MOS:** _____ **Duty Title:** _____

Assigned Unit: _____

Contact Address: _____

Contact Phone: (day) _____ **(evening)** _____

E-mail address: _____

Likely to do travel for the following reasons in the next 4 months? (please circle) PCS Deploy TDY School **Projected date** (if known): _____

2. I certify that the following are true and will inform local MTF eye clinic if Soldiers circumstances change:
   a. Soldier has 18 months remaining on Active Duty
   b. Soldier has no adverse personnel actions pending
   c. Soldier will remain CONUS for at least 60-90 days

3. I realize that after surgery, the Soldier will have up to 4 days of convalescent leave. In addition, I understand that the SM will have the following profile for a minimum of 30 days:
   a. No field duty or driving military vehicles
   b. No organized PT – may do modified individual PT
   c. No swimming, protective mask use, or use of camouflage face paint
   d. May wear sunglasses at all times

4. I further realize that participation in this program requires a considerable investment of time resulting in absences from duty and will ensure that the Soldier will keep all appointments. Minimum requirements are as follows:
   a. Initial evaluation (local medical treatment facility (MTF)) – up to half a day
   b. Surgery – one week off work, up to two weeks, especially if Soldier has to travel for surgery
   c. Postoperative evaluations (local MTF) – normally scheduled 1, 5, 30, and 90 days after surgery

5. I understand that if Soldier needs to travel to another facility to receive refractive surgery, all TDY costs will be incurred by the Unit or the Soldier receiving the elective refractive eye surgery.

Company Commanders Signature	Battalion Commanders Signature
Company Commanders Name and Rank	Battalion Commanders Name and Rank
Date / Phone	Date / Phone
Company Commanders Email Address	Battalion Commanders Email Address

FOR ALL CANDIDATES:

WARFIGHTER LASER SURGERY CENTER
MANAGED CARE AGREEMENT

PATIENT NAME _____ SSN _____

SERVICE/STATUS _____ FORT/LOCATION _____

RANK _____ PHONE _____

PATIENT AGREEMENT

I REQUEST TO BE RETURNED TO DR. _____ FOR POSTOPERATIVE CARE FOLLOWING REFRACTIVE SURGERY AT THE WHMC WARFIGHTER LASER SURGERY CENTER. I KNOW THAT THE STAFF OF THE WARFIGHTER LASER SURGERY CENTER WILL BE AVAILABLE FOR ADDITIONAL CONSULTATION AS NEEDED.

PATIENT SIGNATURE _____ DATE _____

REFERRING DOCTOR'S AGREEMENT

I AM QUALIFIED AND CAPABLE TO MANAGE THIS PATIENT AND I ACCEPT RESPONSIBILITY FOR HIS/HER POSTOPERATIVE CARE. I WILL SUBMIT ALL POSTOPERATIVE FOLLOW UP EXAMS TO THE TREATING WARFIGHTER LASER SURGERY CENTER. I ALSO AGREE TO REFER THIS PATIENT PROMPTLY IF A CONDITION PRESENTS POSTOPERTIVELY THAT WILL REQUIRE FURTHER TREATMENT BY THE WARFIGHTER LASER SURGERY CENTER.

REFERRING OPTOMETRIST SIGNATURE _____ DATE _____

334-255-7185

PRINT OR STAMP NAME, RANK _____ DUTY PHONE _____

Fort Rucker, AL 334-255-7183

FORT/LOCATION _____ DUTY FAX _____

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of the Surgeon General.

REPORT TITLE **PATIENT HISTORY QUESTIONNAIRE** | DATE *(YYYYMMDD)*

Last Name, First Name, MI	Rank/Grade	MOS	Occupation/Duty Title

SSN	Date of Birth	Age	Home Phone	Work Phone	Address

Emergency Contact *(preferably other than spouse)*	Phone	Relationship	Your Primary E-mail

List some of your hobbies or activities that require visual needs:
(example: biking, crafts, computers, sports, etc.)

1. _____
2. _____
3. _____
4.

What do you hope to achieve from having laser eye surgery?
(example "to be able to wake up in the morning and see the clock")

1. _____
2. _____
3. _____
4.

REFRACTIVE HISTORY

How many years have you worn glasses?

Ever worn bifocals? ☐Yes ☐No

How old is your current glasses prescription?

How long have you worn contact lenses?

Last worn? *(DD MMM YYYY)*

Contact lens type: ☐ Soft ☐Rigid

Brand worn:

Have you ever had difficulty with glasses or contact lens wear?
(If YES, please explain further)

OCULAR HISTORY

Do you or have you ever had the following eye problems?

Amblyopia / lazy eye	☐Yes	☐No
Cataracts	☐Yes	☐No
Conjuctivitis, recurrent	☐Yes	☐No
Corneal ulcer	☐Yes	☐No
Double Vision	☐Yes	☐No
Dry eyes	☐Yes	☐No
Glaucoma	☐Yes	☐No
High eye pressure	☐Yes	☐No
Herpes simplex / Zoster	☐Yes	☐No
Keratoconus	☐Yes	☐No
Retinal problems	☐Yes	☐No
Trauma	☐Yes	☐No
Other (specify)		

ALLERGIES

Do you have any allergies to medications? ☐Yes ☐No
(Please list medication and reaction)

MEDICATIONS

Are you taking or have you taken any of the following?

Accutane (isotretinoin)	☐Yes	☐No
Birth control pill	☐Yes	☐No
Cordarone (amiodarone)	☐Yes	☐No
Immunosuppressants	☐Yes	☐No
Imitrex (sumatriptan)	☐Yes	☐No
Steroid medication	☐Yes	☐No

List other medications that you are currently taking:

MEDICAL HISTORY

Do you or have you ever had the following?

Arthritis	☐Yes	☐No
Breathing Problems	☐Yes	☐No
Diabetes	☐Yes	☐No
Heart Problems	☐Yes	☐No
High Blood Pressure	☐Yes	☐No
Migraine Headaches	☐Yes	☐No
Pacemaker	☐Yes	☐No
Immunosuppression/HIV	☐Yes	☐No
Other Medical Problems (specify)		

OCULAR SURGERY

Have you ever had surgery or laser treatments on your eyes?
☐No ☐Yes (specify)

Name of Eye Care Provider	Phone

Patient Signature: _____

SURGERY TECHNICIAN COMMENTS

Technician Signature: _____

SURGERY PHYSICIAN COMMENTS

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	*DATE (YYYYMMDD)*

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)*

☐ HISTORY/PHYSICAL
☐ OTHER EXAMINATION OR EVALUATION
☐ DIAGNOSTIC STUDIES
☐ TREATMENT
☐ FLOW CHART
☐ OTHER *(Specify)*

Aviation Commander's Authorization

Memorandum to: Unit Flight Surgeon

CC: Ophthalmology, Refractive Surgeon

Subject: Authorization for Aircrew members to receive refractive surgery under the Aeromedical Policy Letter for Refractive Surgery and the Corneal Refractive Surgery Surveillance Program.

1. _____, SSN _____ is authorized to receive refractive surgery per the guidance outlined in the Aeromedical Policy Letter: Corneal Refractive Surgery/JAN 2006

2. This authorization is based on the following understandings:

a. This authorization does not constitute a medical waiver; it only authorizes the individual to have refractive surgery. The individual will be DNIF for at least 6 weeks and possibly up to 12 weeks. The medical waiver request will be submitted to USAAMA upon receipt of information from the flight surgeon as to the successful outcome of the individual's surgical procedure. USAAMA will determine if the individual's meets the medical waiver requirements when the applicant's eyes and vision meet and retain FDME standards and all requirements for waiver have been met.

b. Two to 3 of 1000 eyes (0.2 to 0.3%) will not recover 20/20 best-corrected vision after refractive surgery. Individuals who fall in this category will be evaluated by USAAMA to determine whether a waiver to continue on flight status may be issued. Although slight, there is a possibility the individual may lose his/her flight status in the case of significant visual loss that cannot be resolved.

c. Questions about the study may be directed to USAARL at 334-255-6810, about waivers to USAAMA at 334-255-7430, and about refractive surgery to the local eyecare provider.

d. A copy of this correspondence will be kept on file in the local flight surgeon's office.

3. POC is the undersigned at _____.

Commander's Signature Block

FOR AVIATORS:

Corneal Refractive Surgery Checklist for Eye Care Provider Page 1 of 2

Last name: _____ First name: _____ Middle initial: ____
Mailing Address: _____
_____
E-mail Address: _____
Home/Mobile Phone: _____
Date of Birth_____ SSN_____

Eye Care Provider
Surgeon/Doctor's Name: _____
Clinic address & telephone: _____
_____
_____

Specific procedure details (Operative and Pre-Operative Data)

Date of Procedure: _____ Type (circle one) PRK or LASIK
Laser Used (manufacturer):_____ (model #) _____

Ablution parameters (Complete below, or if available, attach copies of laser records.)
OD: Size of ablation: _____*mm* Tissue removed: _____ *microns* # of Pulses: ___
OS: Size of ablation: _____*mm* Tissue removed: _____ *microns* # of Pulses: ___

Amount of correction programmed into laser:
OD: _____ OS: _____

Pre-operative Refraction
OD: _____ OS: _____

Did the applicant require any enhancement procedures? Yes _____ No _____
(If yes, please provide details above)

Post Operative Data:
Follow-up examinations (include most recent and 2 prior examinations(3 total))

DATE	REFRACTION	VISUAL ACUITY	CORNEAL HAZE* (circle one)
	OD: OS:	OD: OS	OD: 0 1 2 3 4 OS: 0 1 2 3 4
	OD: OS:	OD: OS:	OD: 0 1 2 3 4 OS: 0 1 2 3 4
	OD: OS:	OD: OS:	OD: 0 1 2 3 4 OS: 0 1 2 3 4

*** Haze 0-4 scale.** 0=no haze. 1=trace, 2=minimal, 3 moderate, 4=iris details obscured.

Checklist for Eye Care Provider (post operative cont.) Page 2 of 2

Corneal topography (post operative, include a *color* copy of most recent *post-operative* corneal topography using the

TANGENTIAL or INSTANTANEOUS map display option)
Manufacturer: _____
Model: _____
Date of topographies: _____

Contrast Sensitivity (attach copy of post-operative results, if available)
Test Manufacturer & Model: _____
Date of contrast test: _____
Test Conditions:
Room Lights ON (Circle one) Yes No
Backlit Chart (circle one) Yes No
Distance to test _____*m*
% Contrast (if letters) _____%
Results:
OD: _____
OS: _____

Does applicant report any subjective visual changes? (i.e. increased glare, starbursts, halos, etc.)
_____
_____

***For Class IA/1W** (MUST complete a post-operative cycloplegic refraction, noting normal refractive DVA/NVA with
best correction, and IOP's if your 1A/1W FDME data was pre-operative.)

Distant Visual Acuity Near Visual Acuity
OD 20/_____ Corrected to 20/_____ OD 20/_____ Corrected to 20/_____
OS 20/_____ Corrected to 20/_____ OS 20/_____ Corrected to 20/_____

Cycloplegic Refraction:
OD: _____
OS: _____
Pre-Operative Intraocular Tension: OD _____ OS _____

Please return this form and supporting documents to your Flight Surgeon.